MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 22, 2004
10:09 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Purchasing strategies -- Kevin Hayes, Anne Mutti, Jill Bernstein

MS. MUTTI: Last month we presented our work plan and summary findings for our draft purchasing strategies chapter. As you may recall, the purpose of this effort is to explore the range of strategies that private purchasers and other governmental purchasers may be sing to improve the efficiency of health care delivery. Our thought here is that this experience may provide ideas for the management of the Medicare fee-for-service program.

Since the last meeting we have revised our findings, incorporating your comments as well as additional research. We have also added to the chapter a discussion focusing on the strategies used by the private sector to address concerns about the appropriateness and quality of imaging services. This includes a brief assessment of the extent to which the federal government is using similar strategies. Kevin will provide further detail on that in a moment.

Our final new part of the draft raises several of the fundamental issues that must be addressed if these strategies are considered for fee-for-service Medicare, and Jill say that a bit about this. First, let me just turn it over to Kevin though and say that we look forward to getting your comments on the chapter as a whole at the conclusion.

DR. HAYES: We'll talk now about the imaging section of the chapter. One way to think about it is as a kind of case study. It gave us an opportunity focus in on a particular type of service, provide some additional detail on private insurers' purchasing strategies. The other thing it allowed us to do was to look for parallels or similarities between the strategies of private insurers and current activities of the federal government, either on the part of CMS or in the case of, as we'll get to in a minute, mammography facilities of the Food and Drug Administration.

So why imaging services otherwise? First off, we have the matter of last year's June report. Recall that we had a chapter there on growth and variation in the use of physician services. One type of service we paid particular attention to was imaging. It was a case where we found quite a bit of variation geographically in use of the services, and it raised questions, as other research has done, about whether there is some overuse of these services.

The other reason to consider imaging services from a purchasing strategies standpoint has to do with the panel that we had at last month's meeting. From a staff standpoint our perception was that the panel generated a fair amount of discussion among commissioners and was overall well-received, so we wanted to try to summarize what the panelists said and then, as I say, link that to current federal policy.

So the next part of our plan here for this chapter is to

just to summarize what we heard from the panelists. In general we can see that they talked about a number of different strategies. It's useful I think to categorize them into two groups. We have the first three strategies profiling, preauthorization, beneficiary education. These were strategies that we heard about otherwise in interviews with health plan executives. One way to perceive what the panelists said was that it wasn't anything particularly unique about imaging services with respect to these strategies.

On the other hand, the last three, the safety standards, privileging, and coding edits did come across as having been honed a fair amount to focus in on particular issues surrounding imaging services. They really were intended to address half a dozen or so different problems that the private insurers had identified in the market areas where they are operating. They include such things as proliferation of imaging equipment, lack of familiarity with new imaging modalities on the part of some physicians, concerns about self-referral, direct-to-consumer marketing of imaging services, repetition of imaging studies, and poor quality of imaging equipment, or just in general concerns about the technical quality of imaging services.

What I'd like to do now is just briefly summarize what we said about those latter three strategies for the chapter. Turning first to the matter of safety standards and inspections, we heard about a study which showed that failure rates on inspections of imaging facilities approached 50 percent, depending upon the type of practitioner operating the facility. Different kinds of problems were identified, a couple of them had to do first off with the age of equipment; just use of old equipment, used equipment, that kind of thing. The other was incorrect equipment, wrong equipment for the job. We had the vivid example of dental equipment used for x-rays of toes.

So what we have here is a strategy that is essentially in two parts. We have, one, the development of standards, and the second has to do with the field work of actually inspecting the facilities. When we look at current activities of the federal government we see a couple of parallels here. The first has to do with the work of the Food and Drug Administration in inspecting on a regular basis some 9,000 or so outpatient imaging facilities. They do so under authority of the Mammography Quality Standards Act that was passed in 1992.

The other area where we see some similarities has to do with the rather extensive program of survey and certification that is administered by CMS. The standards involved here go by a couple of different names, one, conditions of participation, the other, conditions of coverage kind of depends on the type of the service and setting. But in any case, what we're talking here about is a set of standards primarily for institutional services, hospitals, SNFs, that kind of thing, some Part B coverage having to do with renal dialysis facilities. But the notable exception here is physician services that are not subject to survey and certification at all with the exception of the last item that's listed here which has to do with clinical laboratory services. Under authority of the Clinical Laboratory Improvement Amendments

passed in 1988 CMS is doing survey and certification of clinical labs, many of which are in physician offices. So that's the story with respect to this first strategy, standards and inspections.

Then we can turn to another strategy, privileging, which can be defined as a policy of restricting payment to certain physicians based on things like specialty, qualifications or other criteria. This strategy too is responding to concerns about technical quality as are the safety standards, but also concerns about proliferation of equipment and self-referral.

CMS has some experience with this kind of a strategy. The obvious example here has to do with the policy having to do with coverage for services provided by chiropractors. There is essentially one service covered here and that's manipulation of the spine. Other examples have the do with a recent policy adopted with power-operated vehicles, also known as scooters. Here because of some concerns about fraud and abuse and rapid acceleration and growth in use of these devices CMS has established some criteria saying that only selected physicians can order these things. This would be physicians specializing in rheumatology, physical medicine, orthopedic surgery, or neurology.

The other thing that we could do here is to link the idea of privileging with limits on self-referral. As you know, under the Stark laws there are restrictions on self-referral. Physicians cannot referred Medicare or Medicaid patients to entities which they or members of their family have a financial interest. These entities covered by the law include radiology services, but other things too like laboratory services, physical therapy, home health, and durable medical equipment.

The topic of self-referral admittedly is a very complex one, one that we'll take on in the context of work on a report concerning specialty hospitals, a report that you'll hear about tomorrow. But suffice it to say for now that we have a contractor working on this with some legal expertise in the area. But for now let me just say that one way to think about what the panelists said last month in the context of self-referral is that they view their privileging policies as a way to fill a gap that's not addressed by Stark. That would be that if we think about Stark as covering things like referral to the lab down the street, the imaging center down the street, that leaves then the other form of self-referral, which is referral of patients to in-office equipment; the orthopedic surgeon who has an MRI machine in the office. So we could view the privileging strategies of private insurers as a way to address that form of self-referral not addressed by Stark.

That then brings us to the third strategy here which is coding edits. This one from our perception seems to be the one that's most similar to current Medicare policy. Recall that these coding edits are rules that are invoked during claims processing to make decisions about whether or how much to pay for billed services. Medicare has a system, a mechanism in place for developing these edits called the correct coding initiative, a transparent process that allows for input from the physician

community. The result is a set of edits that are in the public domain, and it turns out that private insurers often use those edits. They then add to them in a couple of different ways.

For example, they might have edits that compare billed services to practice guidelines. They might also make some payment adjustments when multiple services are billed on a single claim. A good example of this would be computed tomography services where they would pay a full payment for -- imagine a patient comes in for two CT services, one of the abdomen, another of the pelvis. They would pay the full rate for one of the procedures, but a discounted rate on the second one.

Medicare has a similar policy like that now for surgical services, but nothing for anything other than that and certainly not for imaging services.

So just to wrap things up here, we have heard from a panel. We've heard about a number of ideas, see some parallels between what private insurers are doing and Medicare policy. The question now is, should we go further in learning more about ways to perhaps adapt these policies for the Medicare program?

Next steps in doing so would include things like looking more closing at what private insurers are doing, comparing that to Medicare and existing policy, and understanding better what the feasibility is of actually importing some of these strategies.

The other thing to learn about would be just effectiveness, and what kinds of savings experience the private insurers have had with these strategies, what the implications are for quality and that kind of thing.

Jill now is going to talk about the idea of next steps from a broader perspective on purchasing strategies overall.

DR. BERNSTEIN: Looking ahead to where we go from here, the chapter ends with a very brief overview of some broad evaluation issues. The first have to do with the current structure of the Medicare program and the chapter includes a brief overview of some issues related to law and regulation and to Medicare's purchasing authority. The other issue look more closely at the specific issues surrounding individual purchasing strategies and what they might mean in fee-for-service Medicare.

A basic question is, how would different purchasing strategies affect Medicare beneficiaries? We would also want to know how a purchasing strategy might affect the delivery system that serves beneficiaries and therefore might affect their access to care. And finally, could the Medicare program administer a particular strategy effectively?

We look forward to your comments on this and the rest of the chapter.

MR. HACKBARTH: Questions or comments?

DR. NEWHOUSE: There was a suggestion made at one point in this chapter on the availability of CMS claims data to other carriers for purposes of profiling, and since in many markets many carriers have very small market shares it's not really feasible for them to profile. I was wondering if we should make a recommendation to the Congress that they authorize that, since my understanding is that CMS is worried that that's beyond their

pay grade to do.

MR. HACKBARTH: Any reaction to that?

MS. MUTTI: We definitely heard that from a number of people that we interviewed, that they would be anxious to get that data, and we understood that CMS was unclear whether they had the legal authority to do that. There was privacy issues raised, concern about people being able to identify beneficiaries. But the advocates of having access to that information pointed out that they thought that it could be done in a way so that beneficiaries' identification was suppressed. But I think some people are concerned about the physician identification being so available.

MR. FEEZOR: That was mentioned at the top of page 10, that gets into what she just said and would be a place if we want to insert that.

MR. HACKBARTH: Other questions, comments?

MR. FEEZOR: Mine dealt more with -- Kevin, first off thank you for your view on the imaging. We somehow need to really drive home just the growth of that even more than perhaps we do.

My comment that struck me most and I felt we were maybe shortchanging our readers a bit was in the reference to the health resource accounts. We talk about conceptually what they're used for, but we don't mention the fact in terms of the pretax, post-tax. We don't get into any discussion on that, and I think that would be very helpful to have that spelled out a little bit more. And then particularly the ability to do any rollover on that, and whether or not we are talking about active versus passive income, since the latter is more applicable to retirees.

Then one other observation, and if didn't come out in your analysis or discussion with other third-party payers, but all on the centers of emphasis, centers of excellence I noticed that geographic distance was not listed as an issue that had to be dealt with. I know in a couple of programs that we looked at when I was on the payers' side, that was a very real thing, the ability to move large amounts of that specialty to areas that were more than 70 or 100 miles away frequently; was a big issue. One of the ways we dealt with that was basically coming up with an accompaniment benefit where you actually pay for families hotel for a brief period a time. If that was not found or any of the folks that you interviewed that was not an issue, then not. But otherwise, it seems to me that's one of the things, real barriers to using the centers of excellence, centers of emphasis.

DR. WOLTER: I'd just underscore, think the self-referral issue is a very important issue and we do have areas that are well-defined where it's clearly identified as a conflict of interest, and then we have other areas where it remains not very well-defined. It is complicated but I think it's an important issue which is driving lots of investment in various parts of the health care sector today. So I'll be quite interested to see what your contractor comes up with and how we might approach defining that even more.

I think the other thing I would just mention in terms of approaches to the rapidly growing cost in imaging -- and I

certainly don't have my hospital or physician or rural hat on right now -- but it is one of the highest margin activities in health care. I think that doesn't mean that people are necessarily doing a lot of inappropriate things. There's lots of reasons why imaging has grown and people need the service, but it is very high margin, so I think payment rates are certainly part of the issue.

DR. MILLER: Kevin said this but I'd just like to draw it out for people, and you've touched on it again so I just want to say it. I think there's one path that we will pursue and plan to pursue where we're going to look at self-referral and talk about how it got where it is and how the rules apply. This gets particularly complicated because we're talking about in-office types of activities where self-referral gets incredibly complicated.

The point I just want people to track on is, what Kevin was reminding us that the panel said is, they go at that issue differently. So they may, instead of going through a self-referral exercise, go through a privileging exercise. I realize for Medicare that's a very complicated policy area. But I just wanted to draw that point for you, that for the private sector, some of these people go at that issue a little bit differently, which is not to say that we won't be taking that issue on. I just wanted to make sure that that point caught people's attention.

MR. HACKBARTH: Others?

Like Allen Feezor, I thought that maybe we could elaborate a little bit more on why we elected to include imaging as an example within this. I think we just cross-reference some previous Medicare work, but I think it might be helpful just to elaborate on the growth and the like without prejudging in any way what policy measures, if any, ought to be taken.

But I do feel like this is a good area for us to explore next year and do intend to come back. Maybe we'll decide it is a fruitful area; maybe not. I don't know. But I think there are a number of reasons, not least of which is what we heard from the panel last time, that we ought to take a close look at this.

DR. NELSON: Somewhere see if you can insert a sentence about the role that direct-to-consumer advertising of these capabilities is playing, because I don't know how it is in other markets but there's sure a lot of stuff on the air about open CTs, and it's not unheard of for patients now to go into their physicians and say, my knee hurts, I want a CAT scan on it. The demand management piece of this is something that at least needs to be acknowledged.

DR. STOWERS: I just read an article again the other day about the increase in x-ray use and that kind of thing is connected to the PLI crisis in the country, and there's a lot more -- we've always had trouble measuring defensive medicine and all of that, but there are some things coming out about that particular crisis going across the country now, increasing the amount of images and ordering them quickly than we did five or six years ago when that person asked for the knee or the abdominal pain or whatever. We're a lot quicker to get the

higher-priced scanning and that kind of thing than we were a few years ago. That's definitely true in our emergency rooms.

MR. HACKBARTH: Anything else?

Okay, thank you.